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6. Calculation of the Direct Medical Education Rate

Direct medical education costs are reflected in the cost report when a facility operates a program that qualifies for medical education reimbursement under Medicare. The routine costs are found in the cost report in Worksheet D, Part III. Ancillary costs are found on Worksheet D, Part IV. These costs are apportioned to Medicaid on the basis of Medicaid days and ancillary charges.

The total hospital-specific routine and ancillary direct medical education costs are added together and multiplied by inflation factors. This result is further divided by the hospital's case-mix index, then is divided by the net number of Medicaid discharges for that hospital. This formula is limited by funding availability that is legislatively appropriated.

Routine medical education costs (Worksheet D, Part III)
\+ Ancillary medical education costs (Worksheet D, Part IV)
= Hospital-specific total direct medical education costs
x Inflation factors
= Hospital-specific total inflated direct medical education cost
÷ Hospital-specific case-mix index
= Case-mix-adjusted hospital-specific direct medical education costs
÷ Net hospital-specific number of net Medicaid discharges
= Hospital-specific case-mix-adjusted inflated direct medical education cost per discharge

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix, index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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7. Calculation of the Disproportionate-Share Rate

The disproportionate share rate is determined using the following formula: Sum the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate. Multiply this sum by the disproportionate share percentage.

8. Calculation of the Indirect Medical Education Rate

The indirect medical education rate is determined using the following formula:

- The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, added to the statewide average capital costs, divided by two.
- The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.
- For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate is determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

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b. The hospital-specific case-mix index is computed by taking each hospital's trimmed claims from the hospital's 2001 specific cost reporting period; summing the assigned DRG weights associated with those claims; and dividing by the total number of Medicaid trimmed claims associated with that specific hospital for that period. For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index is computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

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12. Calculation of Hospital-Specific DRG Payment

The final payment rate, as defined in Section 2, is used to determine the final payment made to a hospital. This final payment rate is multiplied by the weight associated with the patient's assigned DRG. The product of the final payment rate times the DRG weight results in the dollar payment made to a hospital.

13. Explanation of Additional or Reduced Payment to a Facility

Additional payment is made for approved cases meeting or exceeding the Medicaid criteria for day and cost outliers for each DRG. For claims with dates of services ending July 1, 1993, and after, 100% of outlier costs are paid to facilities at the time of remittance. Thresholds for the determination of these outliers are computed during the calculation of the Iowa-specific weights and rebasing. Reduced payments are incurred by a facility due to a patient's unusually short length of stay (short-stay outliers).

Long-stay outliers are incurred when a patient's stay exceeds the upper day-limit threshold. This threshold is defined as the greater of 23 days of care or two standard deviations above the average statewide length of stay for a given DRG. Reimbursement for long-stay outliers is calculated at 60% of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long-stay outliers is made at 100% of the calculated amount and is made when the claim is originally filed for DRG payment.

Short-stay outliers are incurred when a patient's length of stay is greater than two standard deviations below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short-stay outliers is 200% of the average daily rate for each day the patient qualifies up to the full DRG payment. Short-stay outlier claims are subject to PRO review and payment denied for inappropriate admissions.

Cases qualify as cost outliers when costs of service in a given case exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost to charge ratios determined in the base-year cost reports.

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f. Distribution to Qualifying Hospitals for Indirect Medical Education

Distribution of the amount in the fund for indirect medical education will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

g. Qualifying for Disproportionate Share

For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under Section 29j. Hospitals receiving reimbursement as critical access hospitals do not qualify for disproportionate share payments from the fund.

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of:

- 2½ percent, or
- The product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

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For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of:

- 2 ½ percent, or
- The product of 2 ½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

Information contained in the hospital's available 2001 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's inpatient Medicaid utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

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h. Allocation to Fund for Disproportionate Share

The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share related to inpatient services for July 1, 2000, through June 30, 2001, is $6,978,925, adjusted by inflation or utilization increases, if applicable.

i. Distribution to Qualifying Hospitals for Disproportionate Share

Distribution of the amount in the fund for disproportionate share will be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share for months beginning with July 2002, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 1999, through June 30, 2000, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and the Medicaid utilization rate (or for children's hospitals during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age will be used in the forgoing formula.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2003, the state fiscal year used as the source of DRG weights will be updated to July 1, 2002, through June 30, 2003. Thereafter, the state fiscal year used as the source of DRG weights will be updated by a three-year period effective for payments from the fund for July of every third year.

In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments described in Section 30 cannot exceed the amount of the federal cap under Public Law 102-234.

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If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

j. Qualifying for disproportionate share as a children's hospital. Licensed hospitals qualify for disproportionate share payments as a children's hospital if they provide services predominantly to children under 18 years of age or include a distinct area or areas providing services predominantly to children under 18 years of age, are a voting member of the National Association of Children's Hospitals and Related Institutions, and have Medicaid utilization and low-income utilization rates for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age of one percent or greater.

Hospitals wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Medicaid fiscal agent within 20 business days of a request by the department:

1. Base-year cost reports.

2. Medicaid claims data for children under age 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

30. Supplemental Indirect Medical Education and Supplemental Disproportionate Share

In addition to payments from the graduate medical education and disproportionate share fund, payment will be made to all hospitals qualifying for supplemental indirect medical education and supplemental disproportionate share payments. The requirements to receive supplemental payments, the amounts available, and the methodology used for determining payments are as follows:

a. Qualifying for Supplemental Indirect Medical Education

Hospitals qualify for supplemental indirect medical education payments by receiving a direct medical education payment from Iowa Medicaid, qualifying for an indirect medical education payment from Medicare, being an Iowa state-owned hospital with more than 500 beds, and having eight or more separate and distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

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b. Available Amount for Supplemental Indirect Medical Education

The total amount of funding that is available for supplemental indirect medical education for July 1, 2000, through June 30, 2001, is $24,834,207. Adjustments made to this amount are subject to increases allowed pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248).

c. Payments to Qualifying Hospitals for Supplemental Indirect Medical Education

Subject to the amount available, the amount to be distributed to each qualifying hospital for supplemental indirect medical education is determined by the following formula:

1. The statewide average case-mix adjusted operating cost per Medicaid discharge is multiplied by five and divided by two, then added to the statewide average capital costs multiplied by five and divided by two.

2. The resulting sum is then multiplied by the following:

$$\left[\frac{\text{(residents + interns)}}{\text{beds}}\right] \times 1.159$$

The number of interns, residents and beds is based on information contained in the hospital's base period Medicare cost report which will be updated when rebasing and recalibration are performed. Payments for supplemental indirect medical education will be on a monthly basis.

d. Qualifying for Supplemental Disproportionate Share

In-state hospitals that are state-owned acute-care hospitals, that have more than 500 beds, and that qualify for payments from the Graduate Medical Education and Disproportionate Share Fund for disproportionate share, also qualify for supplemental disproportionate share payments.

e. Available Amount for Supplemental Disproportionate Share

To comply with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total amount of disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund and supplemental disproportionate share cannot exceed the amount of the federal cap under Public Law 102-234.

The amount available for supplemental disproportionate share payments will be the lessor of:

- The applicable state appropriation, or

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- The federal cap minus disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund.

In compliance with Medicaid Voluntary Contribution and Provider Specific Tax Amendments (Public Law 102-234), the payments made for disproportionate share are not funded through a previously implemented taxation or donation program outlined under the above referenced law. As there is no tax or donation program used for this funding, any proposed disproportionate-share payments made to providers will not be reflective of taxes or contributions paid to the state of Iowa by that specific provider.

All disproportionate-share payments are funded through Iowa's customary "broad-based" taxation processes in current use, which are not thought to be subject to the restrictions outlined in this law.

Disproportionate-share payments made to hospitals will not exceed 12% of Iowa's overall expenditures for Medical Assistance, or the greater of

- The total disproportionate-share amount for the state, as calculated by the use of the 1923(c)(1) minimal for disproportionate-share hospitals (as provided for in 1923 (f)(2)(B)(ii) of the statute or
- The previous year's allotment cap multiplied by the state growth factor for the current year.

Total Medicaid and disproportionate share payments will not exceed the hospital-specific disproportionate share limits.

If the total calculation for disproportionate share payments from the Graduate Medical Education and Disproportionate Share Fund plus the supplemental disproportionate share payments results in more than the disproportionate share allotment, the payments will be reduced on a pro-rata basis, based on Medicaid discharges.

f. Payments to Qualifying Hospitals for Supplemental Disproportionate Share

Payments for supplemental disproportionate share are made after the end of each federal fiscal year. Subject to the amount available, qualifying hospitals receive a payment of up to 166 percent of the hospital's total calculated reimbursement for all cases paid by the Medicaid fiscal agent within the previous federal fiscal year.

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31. Relationship to Managed Care

All monetary allocations made to fund the Graduate Medical Education and Disproportionate Share Fund for direct medical education, indirect medical education, and routine disproportionate share payment are reimbursed directly to hospitals. These payments have been deducted from all managed care capitation payments as part of the rate-setting methodology. No additional payments for these components will be made to any managed care organizations.